Prenatal Registration Questionnaire

Welcome to the first part of your Prenatal Registration visit. You may either fill out the electronic version or hand write your information. Either way, you must print out the form to place in your record. This is a 17 page document and will take approximately 20-30 minutes of your time.

Please print out the form and ***bring it with you*** to your Prenatal Registration appointment.

The form is required to let your OB/GYN provider know about your medical history and any other important information so that we can provide you with the best prenatal care possible. Since the form takes some time to complete, please have it fully completed prior to your visit with us. If the form has not been completed, it may be necessary to reschedule your appointment. Thank you and we look forward to your visit with us.

OB/GYN Staff

PRINT **SAVE AS**

Patient Learning Needs Assessment

Help Us; Help You… Please answer the following questions for you or your family member. (Answer in reference to the person who is receiving healthcare instruction.) Your responses to these questions will help us to better serve you and your family

- Would you prefer to use a translator when discussing your healthcare? Please list your preferred language. (We will do our best to accommodate your preference)

- I learn better by: (Please circle all that apply).
  ☐ **Doing** ☐ **Hearing** ☐ **Reading** ☐ **Writing**

- I have the following condition(s) that may affect my learning: (Please circle and explain)

  ☐ **Vision Problems** ☐ **Hearing Problems** ☐ **Reading Difficulty** ☐ **Other**

  Please Explain:

- Is there someone that you would like to include in any discussions regarding your Healthcare:

  YES ☐ **NO** ☐ If "**YES**', please supply the name of the person(s) and your relation to that person.

- If necessary, do you have someone that will be able to assist you in taking care of yourself?

  YES ☐ **NO** ☐ If "**YES**", please supply the name of the person(s) and your relation to that person.

- Do you have any spiritual needs or cultural beliefs that may impact the type of medical treatment you receive? **YES** ☐ **NO** ☐ If **"YES"** please specify.

- Do you have any other questions, concerns, or special needs that your Healthcare Provider needs to know about?

I verify that the above answers are true. Please sign at time of visit.
(Patient/Parent or Guardian Signature/Date)

I have reviewed the above and *have taken appropriate action, and it is documented on CHCS II note*.

_____
Prenatal Registration Interviewer's Signature/Date)

Name: _____
(Last, First, MI)
Relationship to Sponsor:_____
Status:_____**Rank/Grade:**_____
Sponsor's Name: LAST _ FIRST MI
Organization:_____
Department:_____
SSN/Identification No._____

NHCP 6013/1C (REV) 4/05

Assnt 1-tool - Help Us Help You Revised 4-05

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PRENATAL QUESTIONNAIRE

Naval Hospital, Camp Pendleton

The purpose of this questionnaire is to collect information that will be used to assist in the medical care of you and your unborn baby. Please answer all questions to the best of your knowledge. The information provided on this form is subject to the provisions of the Privacy Act of 1974.

PLEASE answer the following questions by clicking **YES** or **NO**. Briefly explain the **YES** answers in the comments section below.

IMMEDIATE CONCERNS

1. Are you currently having any vaginal bleeding? **YES** ☐ **NO** ☐
2. Are you currently experiencing any significant abdominal pain/cramping? **YES** ☐ **NO** ☐
3. Do you have a history of ectopic pregnancy? **YES** ☐ **NO** ☐
4. Do you have a history of any severe pelvic infections requiring hospitalization? **YES** ☐ **NO** ☐
5. Do you have a history of pelvic surgery for either infertility or infection? **YES** ☐ **NO** ☐
6. Do you have Diabetes that requires medication? **YES** ☐ **NO** ☐
7. In the last six months has anyone hit you, slapped you or forced you to do something you did not want to do? **YES** ☐ **NO** ☐

COMMENTS:

MENSTRUAL HISTORY

1. What was the first day of your last normal menstrual period? _____ 01/03/1999 _____
2. Was it on time? _____ _____
3. Have you taken any birth control (for example: birth control pills or patch, Depo Provera) in the last year?
   YES ☐ **NO** ☐ If "yes", when did you stop that birth control method? _____
4. How many days from the first day of your period to the first day of your next period? _____
5. How many days does your period last? _____

ADDRESSOGRAPH:

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PREGNANCY HISTORY

(List all previous pregnancies including miscarriages and abortions)

DATE (month/ year)	# WEEKS PREGNANT	LENGTH OF LABOR	BIRTH WEIGHT	SEX (MALE/ FEMALE)	TYPE OF PREGNANCY (VAGINAL, C-SECTION, ECTOPIC, MISCARRIAGE, ABORTION)	PAIN RELIEF IN LABOR (Epidural, IV medication)	PLACE OF DELIVERY	COMPLICATIONS
					Select	Select		
					Select	Select		
					Select	Select		
					Select	Select		
					Select	Select		
					Select	Select		
					Select	Select		

COMMENTS:

ADDRESSOGRAPH:

PRINT

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MEDICAL HISTORY

Have you had or have any of the conditions mentioned below? Please explain any "yes" answers.

1.	Diabetes	**YES** ☐	**NO** ☐
2.	High blood pressure	**YES** ☐	**NO** ☐
3.	Heart disease/ Rheumatic Fever	**YES** ☐	**NO** ☐
4.	Lupus or other autoimmune disease	**YES** ☐	**NO** ☐
5.	Kidney or bladder problems (urinary tract infection)	**YES** ☐	**NO** ☐
6.	Epilepsy or seizures	**YES** ☐	**NO** ☐
7.	Psychiatric diagnosis, or being seen by a psychiatrist/psychologist	**YES** ☐	**NO** ☐
8.	Hepatitis or liver disease	**YES** ☐	**NO** ☐
9.	Blood clots in your legs/ varicosities	**YES** ☐	**NO** ☐
10.	Tendency to bruise or bleed easily	**YES** ☐	**NO** ☐
11.	Thyroid problems	**YES** ☐	**NO** ☐
12.	Trauma or violence	**YES** ☐	**NO** ☐
13.	Blood transfusions	**YES** ☐	**NO** ☐
14.	Do you smoke? (If so, how much? If recently quit, when?)	**YES** ☐	**NO** ☐
15.	Do you use alcohol? (If so, how much?)	**YES** ☐	**NO** ☐
16.	Do you or have you used drugs? (Marijuana, LSD, Heroin, Crystal, Crack, Cocaine)	**YES** ☐	**NO** ☐
17.	Pneumonia, asthma, tuberculosis	**YES** ☐	**NO** ☐
18.	Are you allergic to any medications?	**YES** ☐	**NO** ☐
19.	Do you have a LATEX allergy?	**YES** ☐	**NO** ☐
20.	Breast conditions	**YES** ☐	**NO** ☐
21.	Operations/ hospitalizations (if "YES", please list year and reason)	**YES** ☐	**NO** ☐
22.	Anesthesia complications	**YES** ☐	**NO** ☐
23.	Abnormal pap smear, female or gynecological problems, infertility problems	**YES** ☐	**NO** ☐

COMMENTS

PRINT **SAVE AS**

GENETIC SCREENING

Have you, the baby's father, or anyone in either of your families ever had any of the following problems? Please circle "**YES**" or "**NO**" and explain any "**YES**" answers.

1.	Will you be 35 years old or older when the baby is due?	**YES** ☐	**NO** ☐
2.	Thalassemia (Italian, Greek, Mediterranean, Asian background)	**YES** ☐	**NO** ☐
3.	Neural Tube Defect (Spina Bifida, Meningomyelocele, Anencephaly)	**YES** ☐	**NO** ☐
4.	Congenital Heart Defect	**YES** ☐	**NO** ☐
5.	Down's Syndrome (mongolism)	**YES** ☐	**NO** ☐
6.	Tay-Sachs (Jewish, Cajun, French Canadian)	**YES** ☐	**NO** ☐
7.	Canavan Disease	**YES** ☐	**NO** ☐
8.	Sickle Cell Disease or Trait (African)	**YES** ☐	**NO** ☐
9.	Hemophilia or other blood disorders	**YES** ☐	**NO** ☐
10.	Muscular dystrophy	**YES** ☐	**NO** ☐
11.	Cystic Fibrosis	**YES** ☐	**NO** ☐
12.	Huntington's Chorea	**YES** ☐	**NO** ☐
13.	Do you or the baby's father have any close relatives with mental retardation or autism? If "**YES**", was the person tested for Fragile X?	**YES** ☐ **YES** ☐	**NO** ☐ **NO** ☐
14.	Other genetic or chromosomal disorders	**YES** ☐	**NO** ☐
15.	Do you have any metabolic disorder (Type I Diabeties, PKU)?	**YES** ☐	**NO** ☐
16.	Do you or the baby's father have a birth defect?	**YES** ☐	**NO** ☐
17.	Have you or the baby's father had a stillborn child or three or more first trimester spontaneous pregnancy losses?	**YES** ☐	**NO** ☐
18.	Medications (including supplements, vitamins, herbs or over-the-counter drugs) illicit/recreational drugs/alcohol since your last menstrual period?	**YES** ☐	**NO** ☐
19.	Anything else?	**YES** ☐	**NO** ☐

COMMENTS:

PRINT SAVE AS

INFECTION HISTORY

Do you currently have, have you ever had, or been exposed to any of the following infections?

1.	Tuberculosis (Check yes if you have ever lived with someone diagnosed with Tuberculosis, were stationed overseas, or were born outside of the United States.)	**YES** ☐	**NO** ☐
2.	You or any sexual partners with history of Genital Herpes	**YES** ☐	**NO** ☐
3.	Rash or viral illness since your last menstrual period	**YES** ☐	**NO** ☐
4.	Any sexually transmitted disease (STD) including: Gonorrhea, Chlamydia, HPV, Venereal warts, Syphilis or HIV	**YES** ☐	**NO** ☐
5.	Other infectious condition(s)	**YES** ☐	**NO** ☐

COMMENTS:

SOCIAL/LIFESTYLE HISTORY

(Also see Social Services Needs Assessment)

Please circle "**YES**" or "**NO**". Explain any "**YES**" answers in the space provided.

1.	Is this a planned pregnancy?	**YES** ☐	**NO** ☐
2.	What is the highest level of education you have completed? _____		
3.	What is your occupation?		
4.	Are you a vegetarian?	**YES** ☐	**NO** ☐
5.	Since becoming pregnant, have you been exposed to any x-ray or toxic chemicals?	**YES** ☐	**NO** ☐

COMMENTS

Signatures: Date:

Patient:	
Nurse Review:	
Provider Review:	

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PRENATAL SOCIAL SERVICE NEEDS ASSESSMENT

Naval Hospital, Camp Pendleton

So that we may best assist you, please complete this questionnaire.

Name: _____ Age: _____
Date: _____ Address: Street Apt # City Zip St
Phone: (Home) _____ (Work) _____
Location of Partner:
_____

1. I am:
   ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

2. I live with my:
   ☐ Husband ☐ Boyfriend ☐ Parents ☐ Roommate ☐ By myself

3. I live in:
   ☐ Base housing ☐ House ☐ Apartment ☐ BEQ/BOQ ☐ Other
   (If other please specify) _____

4. I am happy with my living accommodations: ☐ YES ☐ NO

5. I have lived in the San Diego/Orange County area for:
   ☐ Less than a month ☐ 1-6 months ☐ 7-12 months ☐ Over a year

6. I have supportive family/friends in this local area: ☐ YES ☐ NO

7. My partner is supportive of this pregnancy:
   ☐ Very supportive ☐ Somewhat supportive ☐ Not Supportive

8. My primary means of transportation is:
   ☐ Own care ☐ My partner ☐ Friend's car ☐ Public transportation
   ☐ Other (Please specify): _____

9. My current financial status is:
   ☐ Good ☐ Fair ☐ Poor

10. a. This pregnancy was:
    ☐ Planned ☐ Unplanned

    b. If unplanned, what options have you seriously considered:
    ☐ Keeping the child ☐ Adoption ☐ Abortion ☐ Foster Placement

11. This is my first pregnancy: ☐ YES ☐ NO

12. How many children live with you? ____ ____ Ages: _____ _____ _____ _____ _____

ADDRESSOGRAPH

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13. I would best describe my mood regarding pregnancy as:
☐ Happy ☐ Unhappy ☐ Scared ☐ Depressed ☐ Frightened
☐ Other (Please describe):

14. On a whole, I would describe my childhood as:
☐ Happy ☐ Unhappy ☐ Violent ☐ Scary
☐ Other (please describe):

15. In my childhood, I saw a lot of:
☐ Drinking in the home ☐ Drug use ☐ Parental fighting ☐ Sexual abuse
☐ Excessive punishment ☐ Other (please specify):

16. Do you or your partner ever experience any of the following?

	YES	NO
Frequent mood changes	☐	☐
Frequently angry at others	☐	☐
Overwhelmed by life	☐	☐
Frequent family quarrels	☐	☐
Excessive drug use	☐	☐
Excessive alcohol use	☐	☐
Loneliness	☐	☐
Anxiety	☐	☐
Financial worries	☐	☐
Physical abuse	☐	☐
Sexual abuse	☐	☐

17. a. What is your biggest concern right now:

b. How are you adjusting/dealing with this concern?

18. You can help us help you by sharing your concerns. Please check any of the following areas I which you might need information/assistance:

☐ Budgeting	☐ Child care	☐ Career help	☐ Counseling	☐ Family Planning
☐ Nutrition	☐ Housing	☐ Food Programs	☐ Legal assistance	☐ Parenting classes
☐ Goal Setting	☐ Transportation	☐ Safety issues	☐ Items for baby	☐ Other

If other please specify:

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PRENATAL NUTRITION QUESTIONNAIRE

Date: _____

Your nutrition can have an important effect on your baby's health. Please answer these questions by circling the answers that apply to you.

WT: _____ HT: _____ AGE: _____

EATING BEHAVIOR

1. Are you frequently bothered by any of the following? (Check all that apply):
   Nausea ☐ Vomiting ☐ Heartburn ☐ Constipation ☐

2. Do you skip meals at least 3 times a week? **YES** ☐ **NO** ☐

3. Do you try to limit the amount or kind of food you eat to control your weight: **YES** ☐ **NO** ☐

4. Are you on a special diet now: **YES** ☐ **NO** ☐
   If yes, what _____

5. Do you avoid any food for health or religious reasons: **YES** ☐ **NO** ☐
   What Foods _____

FOOD RESOURCES

6. Do you have a working stove? **YES** ☐ **NO** ☐
   Do you have a working refrigerator: **YES** ☐ **NO** ☐

7. Do you sometimes run out of food before you are able to buy more? **YES** ☐ **NO** ☐

8. Can you afford to eat the way you should? **YES** ☐ **NO** ☐

9. Are you receiving food assistance now? **(Check all that apply)** **YES** ☐ **NO** ☐

   Food Stamps ☐ School breakfast ☐ School lunch ☐ WIC ☐

   Donated food/commodities ☐ CSFP ☐ Food from a food pantry, soup kitchen, or food bank ☐

10. Do you feel you need help in obtaining food? **YES** ☐ **NO** ☐

FOOD AND DRINK

11. Which of these did you drink yesterday? (Check all that apply)

Soft drinks ☐ Coffee ☐ Tea ☐ Fruit drink ☐ Orange juice ☐ Grapefruit juice ☐
Other juices ☐ Milk ☐ Kool-Aide ☐ Beer ☐ Wine ☐ Alcoholic drinks ☐
Water ☐ Other beverages (list) _____

ADDRESSOGRAPH

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12. Which of these foods did you eat yesterday? **(Circle all that apply)**

☐Cheese Pizza ☐Macaroni and cheese ☐Yogurt Cereal with milk
☐Other foods made with cheese (Such as tacos, enchiladas, lasagna, cheeseburgers)
☐Corn ☐Potatoes ☐Sweet potatoes ☐Green salad ☐Carrots ☐Collard greens
☐Spinach ☐Turnip greens ☐Broccoli ☐Green beans ☐Green Peas ☐Other vegetables
☐Apples ☐Bananas ☐Berries ☐Grapefruit ☐Melon ☐Oranges
☐Peaches ☐Other fruit ☐Meat ☐Fish ☐Chicken ☐Eggs
☐Peanut Butter ☐Nuts ☐Seeds ☐Dried Beans ☐Cold cuts ☐Hot dogs
☐Bacon ☐Sausage ☐Cake ☐Cookies ☐Doughnuts ☐Pastry
☐Chips ☐French fries
☐Other deep-fried food, such as fried chicken or egg rolls
☐Bread ☐Rolls ☐Rice ☐Cereal ☐Noodles ☐Spaghetti ☐Tortillas

Were any of these whole grain? **YES** ☐ **NO** ☐

13. Is the way you ate yesterday the way you usually eat? **YES** ☐ **NO** ☐

LIFE-STYLE

14. Do you exercise for at least 30 minutes on a regular basis (3x a week or more) **YES** ☐ **NO** ☐

15. Do you ever smoke cigarettes or use smokeless tobacco? **YES** ☐ **NO** ☐

16. Do you ever drink beer, wine, liquor, or any other alcoholic beverages? **YES** ☐ **NO** ☐

17. Which of these do you take? (Circle all that apply)

☐ Prescribed drugs or medications

☐ Any over-the-counter products such as Aspirin, Tylenol, Antacids, or Vitamins

☐ Street drugs such as marijuana, speed, downers, crack, or heroin

18. Medical Condition

Diabetes	**YES** ☐	**NO** ☐
High Blood Pressure	**YES** ☐	**NO** ☐
High Cholesterol	**YES** ☐	**NO** ☐
Food Allergies	**YES** ☐	**NO** ☐

Please List:

Stomach Problems (i.e. Colitis/Ulcers)	YES ☐	YES ☐

Consult Sent: _____

Reason: _____

No Indicated by Screen: _____

*Nutrition during Pregnancy and Lactation and Implementation Guide Institute of Medicine

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PATIENT REGISTRATION
NHCP 6740/9 (REV 12-90)

PATIENT INFORMIATION

LAST NAME	FIRST NAME	MIDDLE NAME	SEX (M OR F)

AGE	DATE OF BIRTH (month-day-year)	RELATIONSHIP TO SPONSOR
		☐ SPONSOR ☐ WIFE ☐ HUSBAND ☐ SON ☐ DAUGHTER

STREET/APT NUMBER	CITY	ZIP CODE	
Street Apt #	City	Zip	☐ OTHER

ID CARD NUMBER	EXPIRATION DATE	HOME PHONE	WORK PHONE

SPONSOR IDENTIFICATION

LAST NAME	FIRST NAME	MIDDLE NAME	RANK/RATE
LAST	FIRST	MI	

SOCIAL SECURITY NUMBER	BRANCH OF SERVICE
	☐ USN ☐ USMC ☐ USA ☐ USAF ☐ OTHER _____

☐ ACTIVE DUTY (Give complete military address a bottom of the page) ☐ RETIRED ☐ DECEASED

EMERGENCY NOTIFICATION

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP

COMPLETE ADDRESS	(TELEPHONE (INCLUDE AREA CODE)

AUTHORIZATION FOR CHART RELEASE (OPTIONAL)

I give permission for my **SPOUSE / PARENTS**

_____

to pick up my chart at any time. It is understood that my spouse / parents must present my I.D. card in order to receive my chart.

Please sign at time of visit. _____
Signature Date

Please sign at time of visit. _____
Witness Date

ALLERGY INFORMATION

LIST ALL KNOWN OR SUSPECTED ALLERGIES

SPONSOR'S ARRIVAL DATE: SPONSOR'S DEPARTURE DATE:

ADDITIONAL REMARKS

MILITARY ADDRESS (Include Company, Battalion, Regiment

Phone

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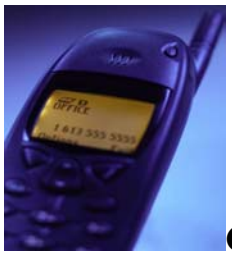
Communication is Important

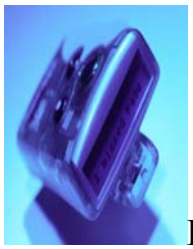
(Please leave us your phone number, e-mail address, cell phone # or Pager #)

Home #

Work #



Cell #



Pager #

E-Mail Address

Name: MI

Sponsor SSN:

Date of Birth:

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DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
NAVAL HAOSPITAL CAMP PENDLETON
CAMP PENDLETON, CA 92055

CONSENT FOR THE HIV ANTIBODY TEST

I have been informed that my blood can be tested in order to detect whether or not I have antibodies to the HIV virus, which is probably the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and using a substance to test the blood.

I have been informed that the test results may, in some cases, indicate that a person has antibodies to the virus when the person does no (false positive) or fail to detect that a person has antibodies to the virus when the person has antibodies (false negative). I also have been informed that a positive blood test result does not mean that I have AIDS and that in order to diagnose AIDS other means must be used in conjunction with the blood test.

I have read and understand the leaflet entitled "Prenatal Screening for AIDS".

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks and alternate tests, I may ask those questions before I decide to consent to the test.

I understand that I will be notified if my test results are either positive or negative and the results will be placed in my prenatal record.

I understand that the results of this blood test will only be released to those health care practitioners directly responsible for my care and treatment. I further understand that no additional release of the results will be made without my written authorization.

****

YES

____ By my signature below I acknowledge that I have been given all of the information I desire concerning the blood test and release of the results and have had all of my questions answered satisfactorily. Further, I acknowledge that **I GIVE CONSENT** for the performance of the blood test to detect antibodies to the HIV virus.

Date: _____ Please sign at time of visit.

Signature

****

NO

_____ By my signature below I acknowledge that I have been given all of the information I desire concerning the AIDS test and have had all my questions answered. Further, I acknowledge that **I DO NOT** wish to have my blood tested for the HIV virus.

Date: _____ Please sign at time of visit.

Signature

NHCP 6470/21 5/89

PRINT SAVE AS

PRIVACY ACT STATEMENT - HEALTH CARE REOCRDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINNING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER *(SSN)*

Sections 133, 1071-87, 3012 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information if voluntary. If the requested information is not furnished, comprehensive health carte may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE
Please sign at time of visit.		

PREVIOUS EDITION IS OBSOLETE S/N 0102-LF-002-0051

FORM
DD 1 FEB 76 2005

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PATIENT ADMISSIONS HEALTH INSURANCE INFORMATION

Do you have a health insurance policy other than TRICARE? ☐ **Yes** ☐ **No**

If you answered yes, you are required to complete the following information:

THIS INFORMATION IS PROTECTED UNDER THE PRIVACY ACT OF 1974.

Policy Holder's Name: _____ Policy Holder's SSN: _____

Patient's Name: _____ Patient's FMP: _____

Sponsor's Name: LAST _____ FIRST _____ Sponsor's SSN: _____

Policy Number: _____ Group Number: _____

Health Insurance Carrier: _____

Address: _____

City, State, Zip: _____

Telephone: _____

PATIENT'S EMPLOYMENT STATUS (Check One) Employed: _____ Retired: _____

PATIENT I certify that the above information is true and accurate to the best of my knowledge. I hereby authorize and request that proceeds off any and all benefits be paid directly to the Uniformed Service Facility or any other authorized representative of the United States for hospitalization and professional services provided my and/or my dependents.	
SIGNATURE: Please sign at time of visit.	**DATE SIGNED:**

FOR OFFICIAL USE ONLY

REGISTER NUMBER:	**DATE OF BIRTH:**
TREATING DOCTOR:	**DIAGNOSTIC CODE:**
ROUTINE / EMERGENCY / SAME DAY SURGERY (CIRCLE ONE)	**ADMISSIONS DATE:**

REVIEWED BY: _____ **SIGNATURE:** Please sign at time of visit.
(PRINT NAME)

NHCP 6150/7A 7-95)

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NAVY-MARINE CORPS
RELIEF SOCIETY
Camp Pendleton
Visiting Nurses

STAFF USE ONLY

Delivery Site:

NHCP____FP____OB____

NMCSD____OTHER____

Congratulations!!

The Visiting Nurse Program would like to make sure you are well prepared for the arrival of a newborn. We will assist you with answers and resources to ensure that the transition to parenting is as smooth as possible.

Please take a few monents to check the areas of information that you are interested in the questionnaire below. Thank You.

1. I would like information on infant feeding: ☐ Breast ☐ Bottle ☐ WIC

   ☐ Please call me for a Breast Feeding Class.

   ☐ I feel comfortable in the areas mentioned above.

2. I would like information on infant care: ☐ Bathing ☐ Dressing ☐ Safety

3. Do you anticipate problems with transportation for:

   ☐ Prenatal Appointments

   ☐ Postpartum appointments (A postpartum appointment is usually a return visit to the hospital usually two to three days after baby is born)

4. Navy-Marine Corps Relief Society Visiting Nurses are a resource and visits can be made before or after your baby arrives. (These visits are not a replacement for your 2 week well baby check or 6 week postpartum checkup).

   ☐ I would like to visiting nurse to contact me now.

Name | Daytime Phone | Sponsor's SSN

Home Telephone Number | Due Date

Address

PRINT SAVE AS

Which number child is this? _____

_____Feeding info given on breast _____ bottle _____ Form # _____ given/mailed _____

Verbal info given by phone/in person _____

_____ Bathing _____ Safety _____ Dressing infants Form # _____ given/mailed _____

Info given on support groups/classes. Form # _____ Verbal _____

_____

_____

Info given on TRICARE _____

Other info given verbal/mailed Form # _____

_____

_____

Date Forms mailed out _____ Given out _____

Home visit scheduled date _____ F/U phone contact date _____

Attempted contact dates _____ _____ _____

A message was left (Y/N) with whom _____ Answering Machine _____

Message _____

_____

_____

_____

Nurses Signature: Please sign at time of visit. _____

PRINT SAVE AS